Health Coverage Reinstatement Agreement Summary

Benefits to Former Enrollees

- Plan will not rescind any coverage issued prior to May 15, 2008.
- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.
- Enrollee may pursue any additional legal remedies.
- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.
- Any medical charges incurred by the former enrollee during the time they had prior Kaiser coverage will either be forgiven or refunded.
- A written claim for additional damages can be submitted and within 60 days, by which the Plan will either offer a financial settlement or reject the claim.
    - If the amount requested is $15,000 or less and includes only medical expenses incurred following the rescission, the case will be decided by an independent third-party review on an expedited basis.
    - If the amount requested is more than $15,000 or includes claim other than medical expenses, the case will be decided through a more formal arbitration hearing process.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.
- Any medical charges incurred by the initial enrollee during the time they had prior coverage to the present will be offered by the Plan in the form of a financial settlement.
- If the financial settlement is disputed, the case will be decided by an independent third-party review on an expedited basis.
- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Plan will pay all medical claims decided through independent arbitration.

- Plan will pay an administrative fine of $300,000 upfront and up to $3 million if it does not complete corrective actions as confirmed through a follow-up medical survey scheduled within the next 18 months.

- On or before June 30, 2008, the DMHC will issue its Final Report of the Non-Routine Medical Survey on Post-Claims Underwriting.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
    - Clear and understandable applications, including health history questionnaires
    - Reasonable look-back time periods on health histories
    - Review of health history prior to issue coverage
    - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents
    - Notification to applicant if a Plan investigation is taking place
    - Any rescission determination is considered by staff independent of original underwriting process
    - An impartial grievance and appeal process

- As noted above, if the Plan does not substantially and implement the corrective actions, confirmed within the next 18 months, the Plan will pay an additional administrative fine of up to $3 million.

- On or before December 31, 2008, the DMHC will conduct a follow-up survey to determine compliance with corrective actions.